San Diego County
CMS Dental Program
Work History Information

The CMS Program policy limits dental services, specifically stay-plates and dentures. We require specific information from the patient to determine if the requested service meets all of the CMS Program guidelines to be a covered service. Your cooperation is appreciated. **ALL questions must be answered and the form attached to the request for dental replacements.**

Date Sent: _____

Patient Name:_____ SSN:_____

Phone Number:_____ DOB:_____

1. What kind of dental service do you need? _____
2. When were your teeth extracted? Month_____Year_____
3. What kind of work do you do when you are working? _____
4. Are you currently employed? [ ] Yes [ ] No
5. Are you currently Receiving State Disability? [ ] Yes [ ] No
6. Are you currently receiving workers compensation? [ ] Yes [ ] No
7. Date you last worked? _____

IF YOU ARE CURRENTLY UNEMPLOYED:

1. Why did you leave your last job?_____
2. Have you applied for or been offered employment in the past six (6) months? [ ] Yes [ ] No
3. Have you recently been turned down for a job because of this medical condition? [ ] Yes [ ] No

TELL US WHO YOUR CURRENT EMPLOYER IS OR ABOUT THE COMPANY WHO HAS OFFERED YOU EMPLOYMENT.

Name of company:_____

Person to contact:_____ Phone:_____

If you are currently employed you can speed up the review process if you would have your employer send a letter on business letterhead. This letter should tell us about your employment and how this condition affects your ability to do your job. Attach the letter to this work history and send them to:

CMS Program
ATTN: Authorization Coordinators
PO Box 939016
San Diego, CA 92193

I authorize the CMS Program to contact the persons/organizations named above to verify the information presented.

Patient Signature: _____ Date: _____

This form must be returned by: _____